Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOSEPH W NAWROCKI MD
P O BOX 741865
DALLAS TX 75374

Carrier's Austin Representative Box
#19

MFDR Date Received
MAY 23, 2012

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-12-2972-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "FUNCTIONAL CAPACITY EVALUATION…REQUIRED TESTING REQUESTED BY THE DESIGNATED DOCTOR…THE CURRENT RULES ALLOW REIMBURSEMENT…AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent signed for the Notice of Medical Fee Dispute on May 25, 2012. The respondent did not submit a response for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2012	CPT Code 97750-FC X 15 Units	$750.00	$750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.204 sets out fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 15, 2012

- *This billing cannot be processed for payment consideration because of the following reason(s): **This bill does not belong to a WC, NS, AN claim**

Explanation of benefits dated April 12, 2012

- *This billing cannot be processed for payment consideration because of the following reason(s): **This bill does not belong to a WC, NS, AN claim**

No payment exception codes or descriptions found on the EOBs provided, no position statement was filed by carrier to clarify EOB denial or payment reasons.

Issues

1. What are the requirements for an FCE per 28 Texas Administrative Code §133.204(g)?
2. Did the requestor document the following required elements of an FCE per 28 Texas Administrative Code §133.204(g) to determine this patient's functional capacity, ability to meet minimum job criteria and/or the need for rehabilitation?
3. Is the requestor entitled to reimbursement?

Findings

1. The documentation submitted by the requestor in this dispute was reviewed. 28 Texas Administrative Code §134.204(g) states that "The following applies to Functional Capacity Evaluations (FCEs): Documentation is required. FCEs shall include the following elements:
   (1) A physical examination and neurological evaluation, which included the following:
      (A) appearance (observational and palpation);
      (B) flexibility of the extremity joint or spinal region (usually observational);
      (C) posture and deformities;
      (D) vascular integrity;
      (E) neurological tests to detect sensory deficit;
      (F) myotomal strength to detect gross motor deficit; and
      (G) reflexes to detect neurological reflex symmetry.
   (2) A physical capacity evaluation of the injured area, which includes the following:
      (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
      (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
   (3) Functional abilities tests, which include the following:
      (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
      (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
      (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
      (D) static positional tolerance (observational determination of tolerance for sitting or standing)."

2. The requestor's documentation was reviewed. The division finds the requestor's submitted documentation sufficiently supports the documentation requirements of an FCE were met in accordance with 28 Texas Administrative Code §134.204(g). 28 Texas Administrative Code §134.204(g) states, in pertinent part, that "FCEs shall be billed using CPT Code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title." Therefore, this dispute will be reviewed according to applicable rules and division fee guidelines.

3. In accordance with 28 Texas Administrative Code, Section §134.203(c)(1) reimbursement is recommended as follows:

   CPT Code 97750-FC x 15 Units: $54.86 WC CF/34.0376 Medicare CF x $32.43 Participating Amount = $52.2689 x 15 Units = $784.03. Per the requestor's *Table of Disputed Services*, the amount in dispute is $750.00, therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.